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REPORT OF A CASE OF HYSTERECTOMY WHERE THE
MORPHOLOGY OF THE TUMOR MADE TOTAL
EXTIRPATION OF THE CERVIX THE
ONLY POSSIBLE PROCEDURE.*

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I hope the gentlemen will pardon me, and yet they might have expected that I could not speak to a medical society without saying something about hysterectomy. In a recent text-book, published in Philadelphia, I believe, they say that Eastman was the first American to make a total extirpation of a fibroid uterus, and add that he did so by a very complicated technique. That statement is to me very objectionable, inasmuch as all my efforts have been to simplify the entire operation of both suprapubic and infrapubic hysterectomy.

I have here a photograph representing a class of tumors with which I have come in contact. From conversations with Dr. Bantock, of London, and Dr. Price, of Philadelphia, I believe they find similar tumors which could not be dealt with at all by the abdominal fixation method. You will see that a fifteen-pound tumor has developed from the anterior wall of the cervix, disorganizing the same, and extended down fully two inches beneath where the lower part of the cervix was found. This tumor was removed by a method which I have been trying to perfect since 1887. It does not make a particle of difference whether we take out the entire cervix or leave a little atom; my preference is to take it all out. I left a piece of cervix in my first case, and the result was satisfactory. I do believe, however, that there are but two methods of hysterectomy now before the world for acceptance or rejection—abdominal fixation and pelvic fixation—one being intra-abdominal and the other intrapelvic. The old terms of intra-peritoneal and extraperitoneal must become obsolete, because of the fact that no one now attempts to fix a pedicle within the peritoneal

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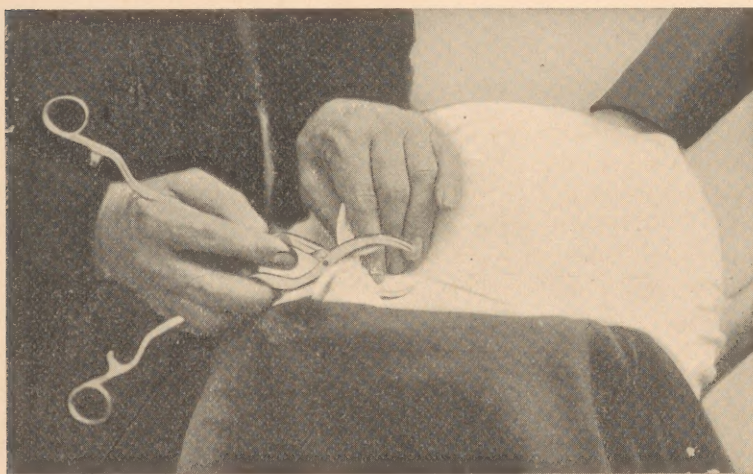
cavity ; they are all extraperitoneal, though the method I speak of is intrapelvic.

I will demonstrate the best I can by means of a pincushion to represent a fibroid tumor. The broad ligaments are not always well



defined, and sometimes can scarcely be found at all. This is true with reference to the cervix. It is not always pear-shaped, but sometimes we have almost to manufacture broad ligaments, and pedicles as well. In order to make the operation as simple and as hurriedly as possible, I have, for about six years, used a broad-ligament forceps in suprapubic hysterectomy to temporarily secure the broad ligament. If we ligate this ligament and go on with our enucleation of the cervix, our ligature may slip. The broad ligament is held by this forceps, which we plunge through the broad ligament and lock, while another pincer may be placed next the tumor. We then cut around the serous membrane, making our anterior and posterior flaps. Joseph Price and myself perfectly agree, so far as this part of the operation is concerned. Then with the finger or any knife handle we enucleate the cervix, keeping between the uterine artery and the uterus. If we have no cutting instrument we will scarcely sever a ureter or have serious hæmorrhage.

The question of closing this wound so as to make a perfect intra-pelvic wound is of a great deal of importance, and really is the very important point of all—to be sure that we not only catch the serous membrane and bring it together, but all loose connective tissue situated between the serous membrane and the vaginal wall. This connective tissue, as you are aware, is rich in lymphatics, the least accumulation there of bloody serum, the slightest pocketing being liable to produce sepsis. I am not disposed to believe that Dr. Bernays was speaking seriously as to the different methods of hysterectomy when he said that they all get well. I have had patients die after the most careful operations I could make, and I think that if all would tell the truth they would say the same thing. If there is one thing above another in pelvic fixation, it is the fact that we must carefully deal with this loose connective tissue. If we simply bring over the serous membrane, we make pockets below; therefore by using a needle like this I go through this connective tissue and use a suture similar to the Halstead suture. After we remove the tumor the ideal way is to contract and bring together the parts which the development of the tumor has separated. This should be cautiously done. Then we suture the serous membrane together with what is practically a Lem-



bert suture. I always pack several pieces of iodoform gauze down into the vagina, leaving an end of one up in the wound.

This, to my mind, is nearly the ideal. The lines of surgical pro-

gression converge toward simplification of operative technique, and the simplicity of any operation is a measure of its success. The idea that we may ligate a broad ligament here or ligate it there is not tenable in every case, because sometimes broad ligaments are wide, sometimes narrow, sometimes can not be found at all. By simply securing the broad ligament and then keeping close to the uterus you can not by any possibility get at any large blood-vessel, nor can you by any possibility reach a ureter. See that the connective tissue is all brought toward where the cervix ought to be, and do not leave any chance for a pocket in which bloody serum might accumulate. The matter of narrowing the broad ligament by a forceps of this kind you all appreciate. Sometimes I have seen several ligatures applied and the ligament ligated in its full breadth.

You will note this forceps has but one large, strong catch. Many catches are objectionable. All my forceps have only one large catch in place of many.

With this method of operating the patient is convalescent in a week. Dr. Etheridge, of Chicago, has seen some cases operated on in this way, and I think he will bear testimony that the patients are practically convalescent on the fourth day, whereas if you fix the pedicle in the abdominal wound it is several weeks before they become so.